

**Policy Academy**  
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**Keynote by Philip Mangano**

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Good afternoon. I know my friends from Massachusetts are here. But now I love all states equally.

Where are we in our collective efforts to respond to homelessness?

Researchers tell us more homeless people. More homeless programs. In fact they tell us 40,000 programs. And as many as 800,000 homeless Americans on any given night. 2 million in the course of a year.

Yet, we know that our sleeves are rolled up and we're breaking a sweat everyday.

We face that irony that has plagued this issue for over a decade.

We're making progress, and falling further behind.

For two decades we've watched people move out of homelessness, only to see more fall in.

We've had expectations.

Even as late as 1987 when the McKinney Act passed and again in the early 1990's when the recession related to a temporary drop in numbers, we thought we could overcome this emergency crisis. This ailment. This social disease.

Two decades later we feel more like Moses wandering The Promised Land than a pilgrim in the New Jerusalem. (That's the faith-based part of my talk.)

Now we wonder if we'll ever see it.

And there are voices that tell us that all of our efforts are in vain. That whatever we do will not be enough. That this issue is an intractable part of the social landscape. There's nothing we can do.

But that's all too heavy for right after lunch. God forbid I give you all indigestion. These days, you'd probably be able to sue me.

No, a story would be better than a polemic. So lean back and let me tell you one about our first President. It's a story of unmet expectations. As you know when he left office after two terms he retired to his beloved Mount Vernon, still a robust hardy man.

Years later he came down with an illness. Nothing extraordinary. But as a precaution his doctor ordered him to bed. When he did not readily get better, concerns arose and his family summoned one of his best friends, a signer of the Declaration of Independence, patriot, Dr. Benjamin Rush, one of the foremost physicians in the country. He came as quickly as he could and found his friend bed-ridden and weak. Dr. Rush quickly examined the former President and concluded that the bad humor in Washington's blood needed to be adjusted. And so he applied the latest medical knowledge to the diagnosis. He bled Washington.

Did he use leeches? We're not sure, but bloodletting was completed and Rush, certain of the appropriateness of his prescription, ensured all that the remedy would take hold within a few weeks. No need to worry. All was under control.

Dr. Rush's expectation was that his diagnosis would bring the cure. Several weeks passed. Word came to him that Washington was not better. In fact, he seemed worse. Rush immediately returned to Mount Vernon and finding his friend even weaker, quickly prescribed another round of blood letting. Rush was certain that those bad humors in the blood needed to be further eliminated. His prescription? More bloodletting. And so he did. When he was through he had exacted nine pints from Washington's body.

Confident that this procedure would be the long sought remedy, Rush returned to Philadelphia. A few weeks later Washington died.

Doctors now tell us that Washington's malady weakened his body and his immune system and that what he really needed was to strengthen his blood. All of it. We are now told that the worst treatment possible for Washington was for him to lose blood.

No one doubts the good intentions of Dr. Rush. He set out to save a life. To treat a friend. His expectation was a remedy, the cure. No one would presume that such a distinguished physician and patriot would engage unknowingly in malpractice.

Records show that Rush was being sued right at that time for his bloodletting prescriptions. Others claimed that this procedure, for which Rush was renowned, was not a cure at all for most. And that "bad humors" didn't exist.

But Rush was confident that his diagnosis of bad humors in the blood, his prescriptions of bloodletting on the body, would produce the cure.

The reality was that the wrong diagnosis led to the wrong prescription, which led to no cure. The unintended consequence of Dr. Rush's treatment was not only no remedy, but also worsening Washington's condition so gravely that the treatment was fatal.

The well intended had the unintended result of making a bad situation worse. And, ultimately, led to an outcome opposite of what was expected.

Medical people call this “iatrogenic.” Treatment that is intended to cure but actually worsens the condition of the patient.

Like deinstitutionalization in the early 70’s. The root of deinstitutionalization was the progressive policy of opening up those nefarious back wards. Shocked by the inhumane treatment chronicled in documentaries by Frederick Wiseman and others, policy makers decided to remedy the situation by a bold and enlightened action. Close those horrid back wards. In fact, close the whole hospital. Offer people a place to live in the community. And integrated life.

We were told and sold that such a shift in policy would remedy an ailing system. Well intended, but iatrogenic it turned out to be.

When we look back on the history of contemporary, pervasive homelessness in our country, we track it back to that deinstitutionalization.

Well intended. Sanctioned by the experts. Supported by policy makers. With iatrogenic results.

Expectations for the good dashed by the results. Community placements without support services and no recourse to hospital readmission left many, if not most, of those deinstitutionalized with a false expectation of hope and cure.

When the ensuing decompensation took place, occasioned most often by withdrawal from meds, these vulnerable neighbors of ours fell to the streets and stayed there. No hospital wards to return to and no housing prospects left these folk on the streets.

And soon enough they were joined by others, at first victims of addiction, then families and then those who are suffering from our country’s recent bouts with “influenza.” That’s right, “influenza.”

You remember them. In the mid 80’s and again in the mid 90’s influenza was all the rage. A terrible drug it was. Most addicting. Many fell under its sway. The rising temperature of the Dow Jones, hyperactive teenage millionaires, swollen 401K retirement accounts.

Old affordable housing units surgically removed from neighborhoods all over the country. In their place artificial housing and neighborhoods implanted like pacemakers. And that operation was, of course, very expensive. So costs associated with housing increased two and three and four fold.

As the markets swelled, whether Dow Jones or downtown condos, many who were in, found themselves out. And needless to say, those most affected by this raging affluenza were the most vulnerable. The disabled by virtue of mental health, addiction, or physical health, the elderly, the young, the very young, children in young families struggling against that rising affluenza tide.

Soon, they, like the deinstitutionalized, had nowhere to go or to stay. Increasingly they found themselves falling unexpectedly (have you ever talked to anyone who expected to be homeless) – falling unexpectedly to shelters and the streets. We don't think that elderly people on fixed incomes, youth aging out of foster care, ex-offenders leaving prison, mothers with young children expect to become homeless, do we?

Well, here we are. Even though that second bout of affluenza came to an end about a year and a half ago, our immune system remains compromised by its dreaded impact.

Like Washington, the vulnerable have bled. Everyone has a different idea about who the leeches have been. Without the correct diagnosis and the resultant appropriate prescription, the remedy is elusive, if attainable at all.

We need to re-look at our diagnosis and the prescription in the expectation of a remedy, a cure. And that's what I want to explore with you – expectations for a remedy.

Diagnosis informed by data and research. Prescriptions customized by research. And the cure, ensured by performance based remedies and results oriented interventions. Sounds like the management agenda of Governors these days. And Presidents.

We're no longer satisfied with managing an iatrogenic response, maintenancing an effort by anecdote, or accommodating a social disease.

No, we're looking for a new standard of expectation. We expect visible, measurable, quantifiable change, in the streets of our county, in our homeless programs, and especially in the lives of homeless people.

No longer are we content to shuffle homeless people from one community to another, from one part of town to the other, from one homeless program to another.

This change is needed, desired, coveted. By policy makers, the Congress, Governors, Mayors, homeless providers and advocates, and, finally, by customers, homeless people themselves.

As customers they hear of the billions being invested and spent and yet their circumstances, the cot, the shelter, the sidewalk, change little. They can't understand where all that investment is going. They're looking for results and not seeing them. So their dilemma is the same as ours.

We all want change. Real change. Substantive change. Not the change promised in those late night infomercials or in all that internet spam we've been getting. Can you believe the volume you're receiving? It used to be with expectation we were informed "you've got mail." Now it's with dread. Sifting through it is painful. Do you just hit delete automatically now? I don't blame you, but there are some entertaining offers on there. (No, not those offers!)

Always the promise of quick, painless, effortless change. You've seen them – a flatter stomach in 15 minutes a day. Learn French while you're in the bathtub, 10 minutes a day. And my new favorite, earn your Bachelor's degree in 10 minutes a day, \$49, or the new advanced course for \$79, earn you PhD while you're sleeping.

Don't we wish change would come like that? Easy, quick. Like the change that the Amish family experienced on their outing. I have to tell for our Pennsylvania participants.

This particular Amish family decided to venture out into the industrialized world. Their first stop was a modern shopping mall. The father and son decided to part company with the mother and daughter and explore the mall on their own.

They happened across two shiny metal doors that intrigued them. They watched as an elderly woman, burdened with shopping bags and looking exhausted from a day spent fighting the mall crowds approached the metal doors. She pushed a button and the doors magically slid open. She stepped inside the small room and the doors magically slid closed behind her. After a few minutes the doors reopened and a beautiful, young and vibrant woman stepped out. The father looked at his son anxiously and said, "Go get your mother!"

Don't we wish change could come like that? Walk into a magic room tired and troubled and come out rested and relaxed.

But you know there are doors that do lead to such magic. Maybe not as quickly as experienced by our Amish friends. But doors that lead to the promise of safety and security and stability, especially for our poorest neighbors.

Those are the doors that open into housing. And that housing is often the nexus point for the services and supports we all need through our lives. To rear our families, to feel safe, to be private and intimate, to share hospitality. Housing is the nexus point of the basics of life. Housing is therapeutic in and of itself. Think of it as the central service – why bifurcate between housing on the one hand and

services on the other – housing is the central service around which all other services are wrapped.

When you're deprived of housing, a lot goes with it; often self-esteem and a sense of worth are the first casualties.

I know all of you recognize that the work you do is far broader than bricks and mortar, services and programs, or grants and loans. Your work gets to the spirit and soul of those you serve, your customers. In creating housing and other services you create the context for all the richness of the human experience.

Your work is offering the gift of expectation in the lives of families and individuals. Expectations of safety, security, family and friends.

With that in mind I'd like to introduce you to a broader sense of expectation. The expectations or lack thereof that we sometimes ascribe to homeless people and the programs that serve them.

Somewhere along the way we got an impression of homeless people. Sometimes through the media. Sometimes in chance encounters. Sometimes in volunteering. Sometimes in programs. Sometimes in those holiday ads that stereotype homeless people as Dickensian figures bent low over their bowl of gruel. Unkempt, dependent.

When that is our image, we adjust our expectations of them. Those encounters on the streets or in programs, where the dependency of homeless people is fully on display, confirms our sense of dumbing down our expectations of them.

And that perception often leaves us underestimating the capacity of homeless people to sustain housing or even desire it. Just as the capacity of mentally ill people, and other people with disabilities was underestimated in the past and now.

How we estimate the capacity of homeless people conditions our response and sets the context for policy directed to homelessness.

If we believe that they are incapable of moving into housing, sustaining and retaining it, investment and policy will reflect that perception. We will be satisfied and contented to manage the issue, to maintain the effort. Outreach and shelters and some transitional efforts will suffice.

But their aspirations are higher than the street or shelter. And our expectations must meet their aspirations. The research and data and experience in the field in innovative programs indicate that we are well founded in moving beyond managing and maintaining.

In fact, as I said earlier, our new standard of expectation is that there will be visible, measurable, quantifiable change on our streets, in homeless programs, and, most especially, in the lives of homeless people. And that expectation is predicated on this fact: There is now a housing technology, that is, strategy, for every profile, subpopulation and individual homeless person. There is no person beyond the engagement and housing strategies being practiced across this country. That's especially true and heartening for the profile of homeless people we're focused on in this Policy Academy.

All over this country disabled and long-term homeless people are moving into housing. Our neighbors who have been on the street living with a disability for a year or two or ten are engaged by clinically based, multi-disciplinary outreach teams and a process begins that places those so-called hard to reach, hard to serve, service resistant, not housing ready citizens, in housing within a week, sometimes two.

It's true. And it's happening all over the country. And the retention rates in that housing which is oriented to the most complex, most disabled, longest term homeless people is 90% plus.

Here's the best part. As we say in Boston, you can look it up. The data and research are done by independent institutions. Not only can you look it up, you can go visit the initiatives. In Massachusetts, New York, San Francisco, Phoenix, Columbus, and other cities, this so-called "Housing First" or Direct Access to Housing or Special Initiative strategy can be visited.

Sometimes the strategic mechanism is the Shelter Plus Care Program of HUD; sometimes downtown redevelopment; sometimes public health systems, and sometimes managed care systems.

The impetus has come from the providers and advocates, from the health care system, from innovators.

What's common to all is that there is now an engagement strategy borrowed from the mental health system known in most places as Assertive Community Treatment Teams – ACT Teams – and a housing strategy developed for vulnerable populations known as supported housing. That combination of "new" technologies applied to homelessness has resolved two long-standing dilemmas:

- First, how do we incorporate customers into decision-making and meet their expectations? In the last number of years, people in systems in whom public resources were invested are increasingly perceived as consumers, customers. The most inductive approach in determining customer choice is to ask the customers their preference. When that is done, nearly all homeless people, no matter what their diagnosis or situation, say that what they want is a place to live. Not a pill, a program, or a plan. I've been asking for the 23 years I've been

involved in this issue, and the response is the same – a place to live. I do it now. Same response.

The direct access to housing philosophy responds to consumer choice, customer demand.

- Second, how do we unravel the dumbing down of homelessness that leaves it as one of those intractable problems on the social landscape? Again the new technologies provide the response. There is a housing technology for every homeless profile. As such the problem is solvable, not intractable.

Dumbing down of expectation concerning homeless people is exposed more as a lack of will than a lack of technology. All over the country the most complex and disabled are sustaining and retaining housing.

So what needs to be done now?  
What are our next steps?

First, for the agnostics – who can't quite believe that the results are authentic, you need to take advantage of the technical assistance offered here and speak to people who have heard, and seen and visited. And, if needed, for your conversion, you should visit the sites and the research. It will only remoralize you and inspire you to the mission.

Once we're all believers (this is part of the faith-based effort), we need to ensure the following:

1. Despite the current economic situation, with egregious cuts on services and housing, we need to continue to fashion the plan that will end chronic homelessness in our states and cities. There are actions that we can take right now to move the strategy forward, whether ensuring the outreach is committed to Medicaid and SSI or focusing our attention on prevention. We are planning for the present and being opportunistic and for the future of renewed investment.
2. With regard to prevention, research is revealing that about half of all people who fall into the front door of homelessness, fall out the back door of mainstream systems of care, detention, incarceration, foster care, substance abuse, and mental health. What makes prevention tangible in these systems is working to ensure appropriate and adequate discharge planning protocols and resources.

While our efforts tend to focus on those already homeless, we need to avoid the "bailing the leaking boat" syndrome. Intervention to move people out, only to see more people fall in. The weakness of past homelessness policy at every level of government and provider response has been insufficient attention to prevention. Prevention ends

homelessness through mainstream resources and programs just as readily as intervention.

In Massachusetts we spent years working to improve prevention through a focus on discharge planning. The workshop tomorrow is a must for every team.

3. One aspect of homelessness we should not dumb down is how expensive homelessness is, especially those who careen around acute systems. In both Phoenix and San Francisco, health systems, managed care and the Department of Public Health respectively, cost containment responses fashioned strategies to create housing targeted to those at risk of and experiencing chronic homelessness. In identifying the expensive “high flyers” in their systems – the 5% of most acute who consume over 40% of the resources – often over \$100,000 per client – managed care in Phoenix and the Department of Public Health in San Francisco adopted a supported housing cost containment strategy. They housed with services the high flyers and saved money doing it.

Recognizing how expensive homeless people are in systems and responding with appropriate and cost saving strategies can result in the housing of many experiencing chronic homelessness. And save money. The Governor’s Office is the proper level for looking at multi-agency investment and response.

4. And, finally, we need more housing targeted to this population to make all our prevention and intervention strategies work. Some of that housing can come through cost saving strategies. Let’s maximize responses that create supported housing and save health systems money.

But we need other sources of targeted housing resources. Each state here will receive such resources through HUD’s SuperNOFA competition. More of the HUD resource needs to be freed up for the most salient antidote to homelessness, housing. [# of continua x \$750,000 or pro rata]

Congress requires a minimum of 30% be spent on new housing. Over the last two years that has created over 9000 units per year. If we could double that investment from the \$360 million plus now invested, we could create housing at a rate that would move us aggressively to accomplishing our objective of eliminating chronic homelessness in the next decade.

To do so, we must free up HUD’s capacity to invest its McKinney funds more deeply in HUD’s mission, housing our poorest neighbors. That relief will come when at the federal, state, and local levels alternative funding is found for the services and employment resources HUD funding now supports.

That's part of our job in this Policy Academy. To identify targeted and, most especially, mainstream resources to relieve the burden on HUD funding to free it to create housing. As we go around the country or into the Congress or speak to homeless people, that housing creation response is uppermost in their minds. "How," they ask, "can we end homelessness without a deeper investment in housing?"

How, indeed. We can't. One source of that deepened investment to create more units for homeless people is HUD's McKinney funds. We need to free them to do their housing work.

That means we need to be creative in pulling down the mainstream resources into the lives of homeless people. The General Accounting Office Report of 1999 indicated that the deep mainstream resources of hundreds of billions of dollars needed to be tapped in our efforts. That's just as true today.

That liberation of HUD resources for housing requires new thinking at the federal, state, county, and local levels in the accessing of mainstream resources. This Policy Academy is part of that effort.

Finally, can we do it? Can we reduce and end chronic homelessness in our country? Some say it is foolhardy to believe such an initiative is possible. That we are foolish and naïve to believe that our efforts will succeed.

These voices that tell us:

- Homelessness is just part of the social landscape. There is nothing you can do about it.
- Everything's been tried. Nothing works.
- They want to be homeless. All you can do is manage the problem.
- Whatever you do is just a drop in the ocean, these voices counsel us.
- Don't waste your time or resources. Relax.
- Don't be foolish. Don't be naïve.

These are the voices content with détente with a social wrong. They've been around for a long, long time. They've expressed doubt, pessimism and cynicism at every movement aimed at ending wrong. They've harassed the abolitionists, the suffragists, civil rights advocates, anti-totalitarians, anti-apartheid efforts.

You can't change things, they say. Well those voices were wrong then and they're wrong now.

All over this country the verb of homelessness is changing. From managing, maintenancing, and accommodating to – ending. Mayors across our country are endorsing 10 year plans to end homelessness. In Indianapolis, Memphis, Columbus, Atlanta, and right here in our nation's third largest city, where Mayor

Daley has endorsed such a 10-year plan. Now he's been called many things in his term, but foolish and naïve are not among them.

The President has called for an initiative to end chronic homelessness. Governors have endorsed 10-year plans to end homelessness in their states.

The nation's second largest city is beginning its planning process to create a 10-year plan to end homelessness in Los Angeles.

Are these Mayors, Governors, and the President all naïve and foolish on this issue? To the contrary, it would be foolish and naïve to think they were.

In England the Blair Government set out to re-commit itself to homelessness several years ago. They chose as their "tipping point" (have you read Malcolm Gladwell's book? – you ought to!) people who were living on the streets, rough sleepers as they're called. Tired of managing the issue without achieving visible and quantifiable results, they created a national strategy, invested modest resources, and implemented.

The voices rose up – you can't do it. It's doomed to failure. It's crazy. The Prime Minister can't be serious.

Two and a half years later rough sleeping in England has been reduced by 60%. We just had a Council meeting at the White House with the architects of the strategy.

The new research, new housing and service technologies, new investment coupled with freeing HUD resources to create housing and HHS, Labor, VA, state and county and local strategies to access the mainstream service resources with equal emphasis on prevention – collaboratively offer the strategy to accomplish our mission.

We are charged, as the abolitionists and suffragists before us, to bring the moral common sense of the future into the present.

The stakes are high. Lives are in the balance. Our vision and our partners must embrace every citizen. Stopping for all, ensuring that no one is left behind. And that everyone will be known by a single name – neighbor – and treated as one.

Thank you.